

## On Site Vaccination Clinic Request

Email address: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Location Name: \_\_\_\_\_

Location Address (please put the address you would like to host the clinic at)

\_\_\_\_\_  
\_\_\_\_\_

**Time Frame:** (ie: back to school, fall clinic, next month) \_\_\_\_\_

**Best Time for Clinic:** Morning Afternoon Evening Other: \_\_\_\_\_

**Day of Week that works best:** Monday Tuesday Wednesday  
Thursday Friday Saturday

**Date Suggestion:** (i.e. August 4th, 8/4/2021) \_\_\_\_\_

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**Type of Location / Population:** (circle all that apply)

Daycare/Preschool

School Grades K-5

School Grades 6-12

Higher Education  
health fairs, etc)

Employees & Staff

Community Clinic (Churches,

Other: \_\_\_\_\_

**What type of clinic?**

Flu

COVID

Routine Immunizations

ALL



Division of  
**Immunization**